AMENDED IN ASSEMBLY AUGUST 2, 2010

AMENDED IN ASSEMBLY JUNE 23, 2010

AMENDED IN SENATE MAY 20, 2010

AMENDED IN SENATE MAY 5, 2010

AMENDED IN SENATE APRIL 8, 2010

SENATE BILL No. 900

Introduced by Senators Alquist and Steinberg
(Coauthor: Senator Pavley)

January 26, 2010

An act *to add Section 1346.2 to, and* to add Division 114 (commencing with Section 135000) to, the Health and Safety Code, *and to add Section 10112.2 to the Insurance Code,* relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 900, as amended, Alquist. California Health Benefits Exchange.

Existing law, the federal Patient Protection and Affordable Care Act, requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and qualified employers, as specified, and meets certain other requirements. Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and the regulation of health insurers by the Department of Insurance. Existing law creates the California Health and Human Services Agency, which consists of various departments.

This bill would establish the California Health Benefits Exchange (the Exchange) within ~~the California Health and Human Services~~

~~Agency~~ *state government* and would require the Exchange to, among other things, implement specified functions imposed by the federal Patient Protection and Affordable Care Act in a consumer-friendly manner, enter into contracts with health care service plans and health insurers seeking to offer coverage in the Exchange, and provide a choice of products in each region of the state between 5 levels of coverage, as specified. Under the bill, carriers participating in the Exchange *that sell products outside the Exchange* would be required to offer, market, and sell all products made available to individuals and small employers in the Exchange to individuals and small employers purchasing coverage outside the Exchange. The bill would authorize the Exchange to take various actions and would require the Exchange to be governed by a board composed of the Secretary of California Health and Human Services and 4 other members appointed by the Governor and the Legislature in a specified manner. The bill would create the California Health Benefits Exchange Fund in the State Treasury and would authorize the board to use moneys in the fund, upon appropriation by the Legislature, for purposes of these provisions. The bill would also require the California Health and Human Services Agency to apply for and receive federal funds for purposes of establishing the Exchange *if a majority of the board of the Exchange has not been appointed, as specified,* and would make those funds available to the agency and the board for those purposes upon appropriation by the Legislature.

The bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner to review an Internet portal developed by the United States Department of Health and Human Services and to jointly develop and maintain an electronic clearinghouse of coverage available in the individual and small group markets if the federal Internet portal does not adequately achieve certain purposes.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1346.2 is added to the Health and Safety Code, to read:

1346.2. The director shall, in coordination with the Insurance Commissioner, review the Internet portal developed by the United States Secretary of Health and Human Services under subdivision (a) of Section 1103 of the federal Patient Protection and Affordable

Care Act (Public Law 111-148) and paragraph (5) of subdivision (c) of Section 1311 of that act, and any enhancements to that portal expected to be implemented by the secretary on or before January 1, 2015. The review shall examine whether the Internet portal provides sufficient information regarding all health benefit products offered by health care service plans and health insurers in the individual and small employer markets in California to facilitate fair and affirmative marketing of all individual and small employer plans, particularly outside the California Health Benefits Exchange created under Division 114 (commencing with Section 135000). If the director and the Insurance Commissioner jointly determine that the Internet portal does not adequately achieve those purposes, they shall jointly develop and maintain an electronic clearinghouse to achieve those purposes. In performing this function, the director and the Insurance Commissioner shall routinely monitor individual and small employer benefit filings with, and complaints submitted by individuals and small employers, to their respective departments, and shall use any other available means to maintain the clearinghouse.

~~SECTION 1.~~

SEC. 2. Division 114 (commencing with Section 135000) is added to the Health and Safety Code, to read:

DIVISION 114. CALIFORNIA HEALTH BENEFITS EXCHANGE

135000. There is hereby established in ~~the California Health and Human Services Agency,~~ *state government* the California Health Benefits Exchange.

135001. For purposes of this division, the following definitions shall apply:

(a) "Board" means the board described in subdivision ~~(j)~~ *(k)* of Section 135005.

(b) "Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345, licensed by the Department of Managed Health Care, including, but not limited to, a local initiative plan, a county-organized health system, or a joint venture of local initiative plans and county-organized health systems.

(c) "Exchange" means the California Health Benefits Exchange established by Section 135000.

(d) "Fund" means the California Health Benefits Fund established pursuant to Section 135011.

(e) "Health plan" and "qualified health plan" have the same meanings as those terms are defined in Section 1301 of the Act.

(f) "SHOP Program" means the Small Business Health Options Program administered pursuant to subdivision (g) of Section 135005.

~~(f)~~

(g) "The Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

135002. (a) The purpose of this division is to implement the provisions of the Act requiring the establishment of an American Health Benefit Exchange in this state by creating an exchange in state government.

(b) The purpose and mission of the Exchange is to make quality and affordable health care coverage available to eligible Californians and to meet the requirements of the Act.

135003. It is the intent of the Legislature that the Exchange do all of the following:

(a) Provide a consumer friendly process that facilitates the seamless enrollment of individuals in health care coverage.

(b) Provide an easily understandable marketplace for purchasing health care coverage where consumers can identify their appropriate and affordable health care coverage choice and, if eligible, claim their federal tax and cost-sharing subsidy.

(c) Organize the health care coverage and cost choices within the Exchange to facilitate competition based on price and quality.

135004. The Exchange shall meet the requirements imposed by the Act, and perform all of the following functions in a consumer-friendly manner:

(a) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(b) Maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans.

(c) Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed under paragraph (3) of subdivision (c) of Section 1311 of the Act.

(d) Utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Service Act.

(e) Consistent with the system established under Section 1413 of the Act, inform individuals of eligibility requirements for the Medi-Cal program, the Healthy Families Program, or any applicable state or local public health care coverage program and, if, through screening of an application by the Exchange, the Exchange determines that an individual is eligible for any of those programs, enroll the individual in that program.

(f) Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under Section 1402 of the Act.

(g) Grant a certification, subject to Section 1411 of the Act and any implementing regulations, attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because of either of the following:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual.

(2) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty.

135005. In addition to meeting the requirements of the Act, the Exchange shall do all of the following:

~~(a) Develop and maintain an electronic clearinghouse of all products offered to individuals and small employers by carriers both inside and outside of the Exchange to assist individuals and small employers in understanding and comparing the available products and in making their coverage purchasing decision. In developing the electronic clearinghouse, the board may require carriers participating in the Exchange to make available and~~

~~regularly update an electronic directory of contracting health care providers so individuals seeking coverage through the Exchange can search by health care provider name to determine which health plans in the Exchange include that health care provider in their network, and whether that health care provider is accepting new patients for that particular health plan.~~

(a) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange.

(b) Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral, and enrollment in the Exchange of individuals applying for assistance to those entities, if allowed or required by federal law.

~~(b)~~

(c) Negotiate and enter into contracts, including selective carrier contracts, with carriers seeking to offer coverage in the Exchange.

~~(c)~~

(d) Determine the participation requirements, standards, and selection criteria for carriers and products offered through the Exchange, which may include, but are not limited to, standards that encourage the use of delivery systems that deliver cost-effective, high-quality care.

~~(d)~~

(e) Provide a choice of products in each region of the state, including a choice in each region of the state between the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the Act.

~~(e)~~

(f) Require, as a condition of participation in the Exchange, carriers *that sell any products outside the Exchange* to do both of the following:

(1) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(2) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

~~(f)~~

(g) Administer a separate Small Business Health Options Program (SHOP) that is designed to assist small employers in facilitating the enrollment of their employees in ~~products offered in the small group market through the Exchange.~~ *qualified health plans offered through the Exchange in the small group market in a manner consistent with paragraph (2) of subdivision (a) of Section 1312 of the Act.*

~~(g)~~

(h) Undertake activities necessary to market and publicize the ~~availability of health care coverage through the Exchange.~~ *availability of health care coverage and federal subsidies through the Exchange. The board shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.*

~~(h)~~

(i) Select and set performance standards and compensation for navigators selected pursuant to subdivision (i) of Section 1311 of the Act.

~~(i)~~

(j) Employ necessary staff, including actuarial staff.

~~(j)~~

(k) (1) Be governed by a board consisting of five members. Of the five members, two shall be appointed by the Governor, one shall be appointed by the Senate Committee on Rules, and one shall be appointed by the Speaker of the Assembly. *In making appointments to the board, the appointing authorities shall take into consideration the cultural, ethnic, and geographical diversity of the state so that the board's composition reflects the communities of California.* The Secretary of California Health and Human Services or his or her designee shall serve as an ex officio voting member.

(2) Members of the board, *other than an ex officio member,* shall be appointed for a term of four years. Vacancies shall be filled by appointment for the unexpired term.

(3) Each person appointed to the board shall have demonstrated and acknowledged expertise in at least two of the following areas:

~~(A) The health care coverage market.~~

~~(B) The small group health care coverage market.~~

(A) Individual health care coverage.

(B) Small group health care coverage.

(C) Health benefits plan administration.

(D) Health care finance.

(E) Administering a public or private health care delivery system.

(F) Health plan purchasing.

(4) Each member of the board shall have the responsibility and duty to meet the requirements of this division and the Act, to serve the public interest of the individuals and small businesses seeking health care coverage through the Exchange, and to ensure the operational well-being and fiscal solvency of the Exchange.

(5) The chairperson of the board shall hire an executive director to organize, administer, and manage the operations of the ~~Exchange, and to serve as secretary and as an ex officio nonvoting member of the board.~~ *Exchange. The executive director shall serve at the pleasure of the board.*

(6) A member of the board shall not be employed by, a consultant for, a member of the board of directors of, affiliated with, an agent of, or otherwise a representative of, any carrier or other insurer, agent, or broker, or a health care provider, health care facility, or health clinic *while serving on the board and during the first year following his or her service on the board*. A board member shall not receive compensation for his or her service on the board but may receive per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(7) No member of the board shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or on either of the following:

(A) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars ($250) or more in

value provided to, received by, or promised to the member within 12 months prior to the time when the decision is made.

(B) Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

~~(7)~~

(8) The board shall hold public meetings and be subject to the requirements of the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code), except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and the development of rates.

~~(k) Receive~~

(l) Apply for and receive federal funds for purposes of establishing and administering the Exchange, including funds made available pursuant to Section 1311 of the Act.

(m) Report, or contract with an independent entity to report, to the Legislature by December 1, 2018, on whether to adopt the option in paragraph (3) of subdivision (c) of Section 1312 of the Act to merge the individual and small group markets. In its report, the board shall provide information, based on at least two years of data from the Exchange, on the potential impact on rates paid by individuals and by small employers in a merged individual and small group market, as compared to rates paid by individuals and small employers if separate individual and small group markets are maintained. A report made pursuant to this subdivision shall be submitted pursuant to Section 9795 of the Government Code.

(n) With respect to the SHOP Program, collect premiums and administer all other necessary and related tasks, including, but not limited to, enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified small employers.

(o) Ensure that the Exchange provides oral interpretation services in any language for individuals seeking coverage through the Exchange and makes available a toll-free telephone number for the hearing and speech impaired. The board shall ensure that written information made available by the Exchange is presented in a plainly worded, easily understandable format and made available in prevalent languages.

135006. The Exchange may do any of the following:

(a) Issue rules and regulations, as necessary. Until January 1, ~~2014~~ *2016*, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(b) Apply for and receive funds from private foundations.

~~(c) Report, or contract with an independent entity to report, to the Legislature on whether to adopt the option in subdivision (b) of Section 1311 of the Act to provide a single exchange for providing services to both qualified individuals and qualified small employers. The report shall provide data on the impact of having a single exchange with a merged individual and small group market on rates paid by individuals and by small employers, as compared to the impact on those rates of having separate exchanges for the individual and small group markets. A report submitted under this subdivision shall be submitted in compliance with Section 9795 of the Government Code. This subdivision shall become inoperative on January 1, 2016.~~

(c) Collaborate with the State Department of Health Care Services, to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or the Healthy Families Program, or loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits through the Exchange.

(d) Share information with relevant state departments, consistent with the confidentiality provisions in Section 1411 of the Act, necessary for the administration of the Exchange.

(e) Require carriers participating in the Exchange to make available to the Exchange and regularly update an electronic directory of contracting health care providers so that individuals seeking coverage through the Exchange can search by health care provider name to determine which health plans in the Exchange include that health care provider in their network. The board may also require a carrier to provide regularly updated information to the Exchange as to whether a health care provider is accepting

new patients for a particular health plan. The Exchange may provide an integrated and uniform consumer directory of health care providers indicating which carriers the providers contract with and whether the providers are currently accepting new patients. The Exchange may also establish methods by which health care providers may transmit relevant information directly to the Exchange, rather than through a carrier.

(f) Require carriers participating in the Exchange to immediately notify the Exchange, under the terms and conditions established by the board, when an individual is or will be enrolled in or disenrolled from any qualified health plan offered by the carrier.

~~(d)~~

(g) Enter into other contracts as are necessary or proper to carry out the duties of the Exchange~~, including, but not limited to, contracts for enrollment processing~~.

~~(e) Determine the health benefits coverage for small employers that the Exchange will contract to purchase from participating carriers.~~

(h) Determine the cost sharing in health benefits coverage that the Exchange will contract to make available from participating carriers.

(i) With respect to individual coverage made available in the Exchange, collect premiums and assist in the administration of subsidies.

~~(f)~~

(j) Appoint committees, as necessary, to provide technical assistance in the operation of the Exchange.

~~(g)~~

(k) Undertake activities necessary to administer the Exchange, including marketing and publicizing the Exchange and establishing rules, conditions, and procedures for ensuring carrier, employer, and enrollee compliance with Exchange requirements, consistent with federal law and regulations.

~~(h)~~

(l) Consistent with federal procedures established under subdivision (e) of Section 1312 of the Act, establish procedures to allow agents or brokers to do both of the following:

(1) Enroll individuals in any qualified health plan in the individual or small group market as soon as the plan is offered through the Exchange.

(2) Assist individuals in applying for premium tax credits and cost-sharing reductions for health plans sold through the Exchange.

~~(i)~~

(m) Consistent with subdivision (d) of Section 1311 of the Act, ~~include within the premiums charged to enrollees or employers purchasing coverage through the Exchange an amount sufficient to pay the actual, reasonable, and necessary administrative costs of the Exchange.~~ *assess a charge, at the lowest possible rate, on the qualified health plans offered by carriers to support the development, operations, and prudent cash management of the Exchange. This charge shall not affect the requirement under Section 1301 of the Act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange.*

135006.1. The Exchange shall only collect information from individuals or designees of individuals necessary to administer the Exchange and consistent with Section 1411 of the Act.

135007. (a) Notwithstanding any other provision of law, the Exchange shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care.

(b) Carriers that contract with the Exchange shall be in good standing with their respective regulatory agencies.

135008. (a) If an individual or an employer is dissatisfied with any action or failure to act that has occurred in connection with eligibility for, or enrollment in, the Exchange, the individual or employer shall have the right to appeal to the board and shall be accorded an opportunity for a fair hearing. Hearings shall be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code to the extent those provisions are consistent with appeals requirements imposed under the Act.

(b) Notwithstanding subdivision (a), the board shall not be required to provide an appeal ~~concerning a coverage determination~~ if the subject of the appeal is within the jurisdiction of the Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) and its implementing regulations, or within the jurisdiction of the Department of Insurance pursuant to the Insurance Code and its implementing regulations.

135009. Nothing in this division shall be construed to compel an individual to enroll in a qualified health plan or to participate in the Exchange.

~~135010. The California Health and Human Services Agency shall apply for and receive federal funds for purposes of establishing the Exchange, including funds made available pursuant to Section 1311 of the Act.~~

135010. If a majority of the board has not been appointed when the United States Secretary of Health and Human Services makes the initial planning and establishment grants available under Section 1311 of the Act, the California Health and Human Services Agency shall submit the initial application for planning and establishment grants to the United States Secretary of Health and Human Services.

135010.5. There shall not be any liability in a private capacity on the part of the board or any member of the board, or any officer or employee of the board, for or on account of any act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this division or affairs related to this division.

135011. (a) The California Health Benefits Exchange Fund is hereby created in the State Treasury as a special fund consisting of revenue necessary for the purposes of this division. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year and may be spent without regard to fiscal year.

(b) The board shall establish a prudent reserve in the fund.

(c) Notwithstanding any other provision of law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the General Fund, or a county general fund or any other county fund.

(d) Except as provided in subdivision (e), moneys in the fund shall, upon appropriation by the Legislature, be used by the board for the purposes of this division.

(e) Moneys in the fund received pursuant to Section 135010 shall, upon appropriation by the Legislature, be used by the California Health and Human Services Agency or the board for purposes of establishing the Exchange.

(f) Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund.

SEC. 3. Section 10112.2 is added to the Insurance Code, to read:

10112.2. The commissioner shall, in coordination with the Director of the Department of Managed Health Care, review the Internet portal developed by the United States Secretary of Health and Human Services under subdivision (a) of Section 1103 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and paragraph (5) of subdivision (c) of Section 1311 of that act, and any enhancements to that portal expected to be implemented by the secretary on or before January 1, 2015. The review shall examine whether the Internet portal provides sufficient information regarding all health benefit products offered by health care service plans and health insurers in the individual and small employer markets in California to facilitate fair and affirmative marketing of all individual and small employer plans, particularly outside the Health Benefits Exchange created under Division 114 (commencing with Section 135000) of the Health and Safety Code. If the commissioner and the Director of the Department of Managed Health Care jointly determine that the Internet portal does not adequately achieve those purposes, they shall jointly develop and maintain an electronic clearinghouse to achieve those purposes. In performing this function, the commissioner and the Director of the Department of Managed Health Care shall routinely monitor individual and small employer benefit filings with, and complaints submitted by individuals and small employers to, their respective departments, and shall use any other available means to maintain the clearinghouse.

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